Adapting the Continuing Care Clinic Model for Multicultural and Uninsured Populations with Diabetes

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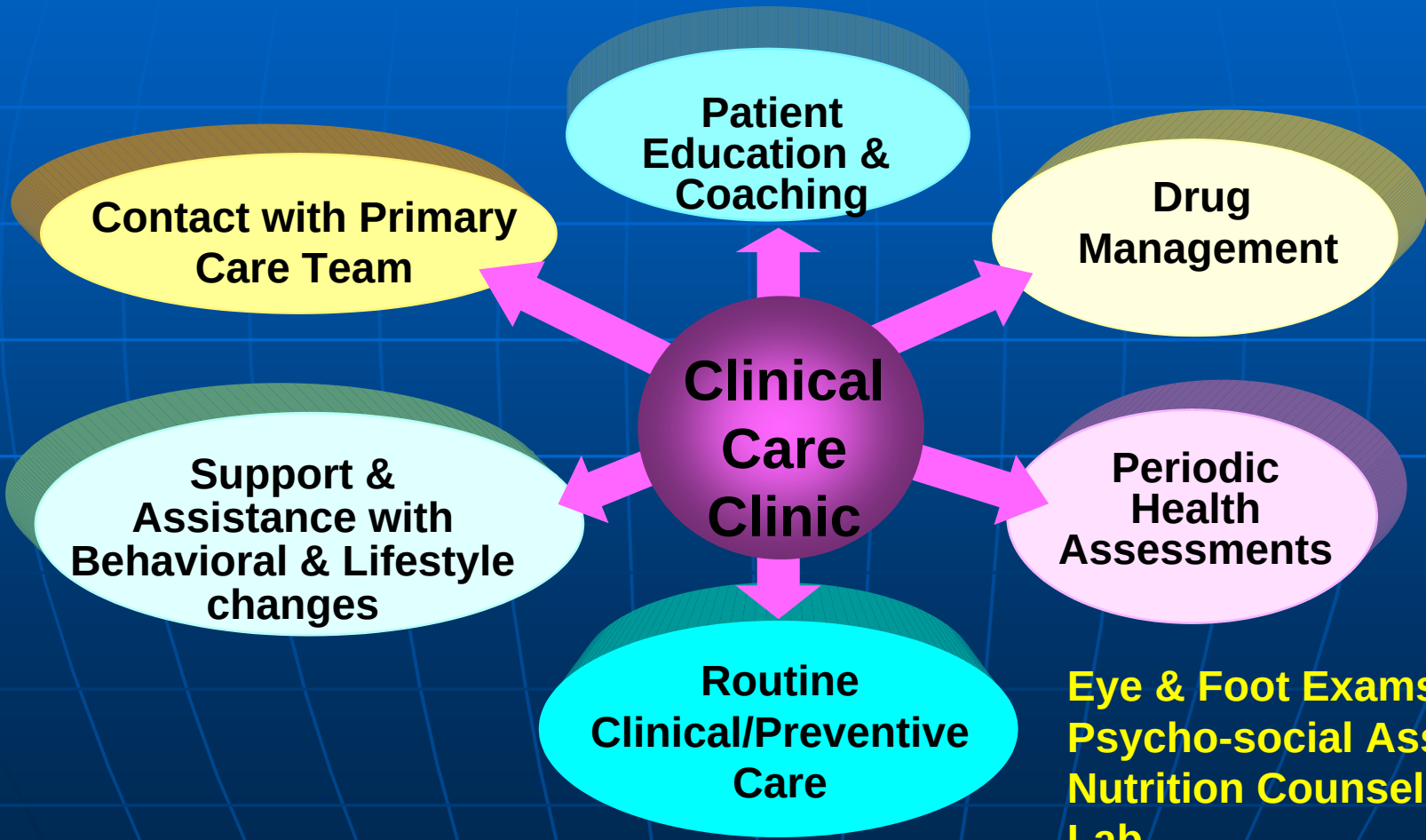
ADHS

Objectives

- Identify recruitment strategies
- Define group visit structure
- Discuss culturally-sensitive group education and self-management materials
- Discuss attendance and adherence strategies

Elements of Continuing Care Clinic



Eye & Foot Exams
Psycho-social Assess
Nutrition Counseling
Lab
Lifestyle Assessment

Case Study: St. Elizabeth of Hungary Clinic, Tucson AZ

- Faith-based CHC serving the uninsured and underinsured
- Primary, Specialty & Dental Care for approximately 18,000 patients
- 2 Physicians, 3 FNPs, and More than 170 volunteer providers
- All direct care staff are bilingual

Population Served

- More than 500 Patients with Diabetes covered through the ADHS Primary Care Program
- 75% Hispanic

Diabetes Disease Management

- ***Diabetes Planned Visits***: Individual quarters diabetes visits with PCP
- ***Diabetes Day Group Visits***: Monthly clinics for patients with diabetes to complete their annual exams (e.g. Retinopathy and Podiatry exams), receive group education and set self-management goals with Promotora. Referral into Education Classes
- ***Continuing Care Clinic***: Quarterly Planned Diabetes Visits for same aggregate group. Receives annual exams, PCP visit, group education and Promotora phone follow up.

Recruitment Strategies for CCC

- ***First Strategy***: Initially Recruited from Diabetes Group Day Visits with HbA1c>8 (n=69; able to make contact with 30)
  - 10 people agreed to attend
  - Poor Show Rate = 5
- ***Second Strategy***: Provider Referred & change day and time
  - 10 people agreed to attend
  - Poor Show Rate = 2
- ***Third Strategy***: Ask the nurses, “Who will come?”
  - 20 people were identified
  - 15 people attended
  - 11-12 consistently come

CCC Structure

- Vital Signs (BP, Pulse, Ht, Wt, A1c)
- Individual 15 minute Visits with:
  - PCP Provider.doc
  - Registered Dietitian
  - Volunteer Provider for Pharmacy
  - Promotora for Self Management Promotora-SMG.doc
  - Specialty Visit (Podiatrist, Dental Hygienist, Behavioral Health)
- Group Education:
  - Exercise
  - Holiday Cooking
  - Stress Management

CCCChecklist.doc

Group Education & Self Management

- Exercise

Englishpersonalrecord.pdf

Spanishpersonalrecord2.pdf

Attendance & Adherence Strategies

- Incentives with each CCC
  - Pedometer & Water Bottles
  - Dentist Visit Coupon
  - Behavioral Visit Health Coupon
  - Healthy Meal/Snack
  - $5 Pharmacy Assistance Program Coupon
- Promotoras
  - Regular Phone Contacts
  - Self Management Follow up

Outcomes

- ***Adherence***: The “show” rate was much better at 75%. The first two groups had a 50% and 22% show rate respectively.

- ***Patient satisfaction*** survey results showed that 100% (n=12) of the patients completed the surveys and 93% rated the program excellent summarized from Questions 1-7. Comments:
  - The day was excellent (2)
  - The exercise program was excellent
  - They like that they know what to do now
  - They know how to get their medications.

A1c Results of CCC Participants

Date	June 2004	Sept 2004	Dec 2004
A1c	8.5	6.84	7.13
Number	15	11	10

Case Study:
Mountain Park Health Center

Continuing Care Clinic

Participant Example

47 year old female seen in 2002 for the first time. Presented with c/o headaches, fatigue, and neck pain. Random BS was 426, HbAlC 11.4, LDL 149, BP 169/106. Patient had been taking medication from Mexico but did not know names or dosages of medication.

RESULTS

1st visit	2nd visit	3rd visit
HbAlC: 12.4	10.8	7.4
Random BS: 426	245	91
LDL: 149	126	149
BP: 169/106	155/102	130/90

Population Served

- The target group for the diabetes continuing care clinic were current and newly diagnosed Mountain Park Health Center patients with type 2 diabetes.

- For the calendar year 2001, MPHC had provided care to approximately 600 uninsured individuals.

Recruitment Strategies

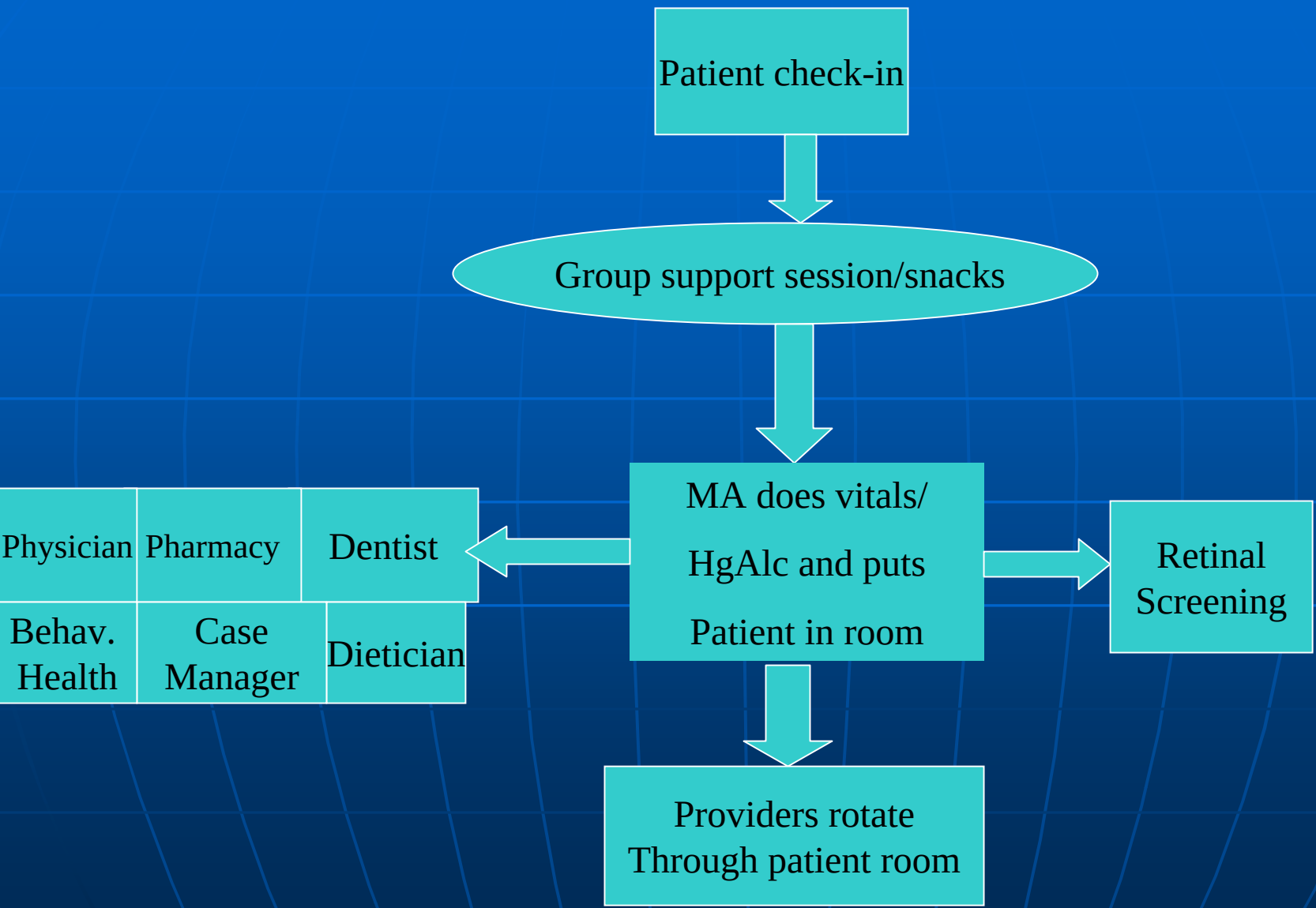
- Mountain Park Health Center utilized our practice management database.
- Eligibility included persons on the sliding fee scale program (individuals without health insurance) with a diagnosis of type 2 diabetes and who had been seen at MPHC since July 1, 2002.
- Seventy-two patients were randomly selected to participate.

CCC Structure

- Patients are called and scheduled one week before clinic
- Charts pulled
- Super-bills run
- MA triages patient
- Patients meet with Behavioral Health for half-hour class
- HbAlc/Lipids done in clinic
- Providers float through exam room
- Retinal screening

CCC Process

- Data entry staff member keeps track of patients that are in clinic and organizes the schedule. She pulls the charts and runs the super-bills the day before clinic.
- Medical Assistant triages patient and if needed does a HbAlc and checks cholesterol before putting patient in the room.
- Once the patient is in the room, the providers begin to rotate to see the patients


Patient check-in
Group support session/snacks
MA does vitals/
HgAlc and puts
Patient in room
Physician
Pharmacy
Dentist
Behav. Health
Case Manager
Dietician
Retinal Screening
Providers rotate
Through patient room

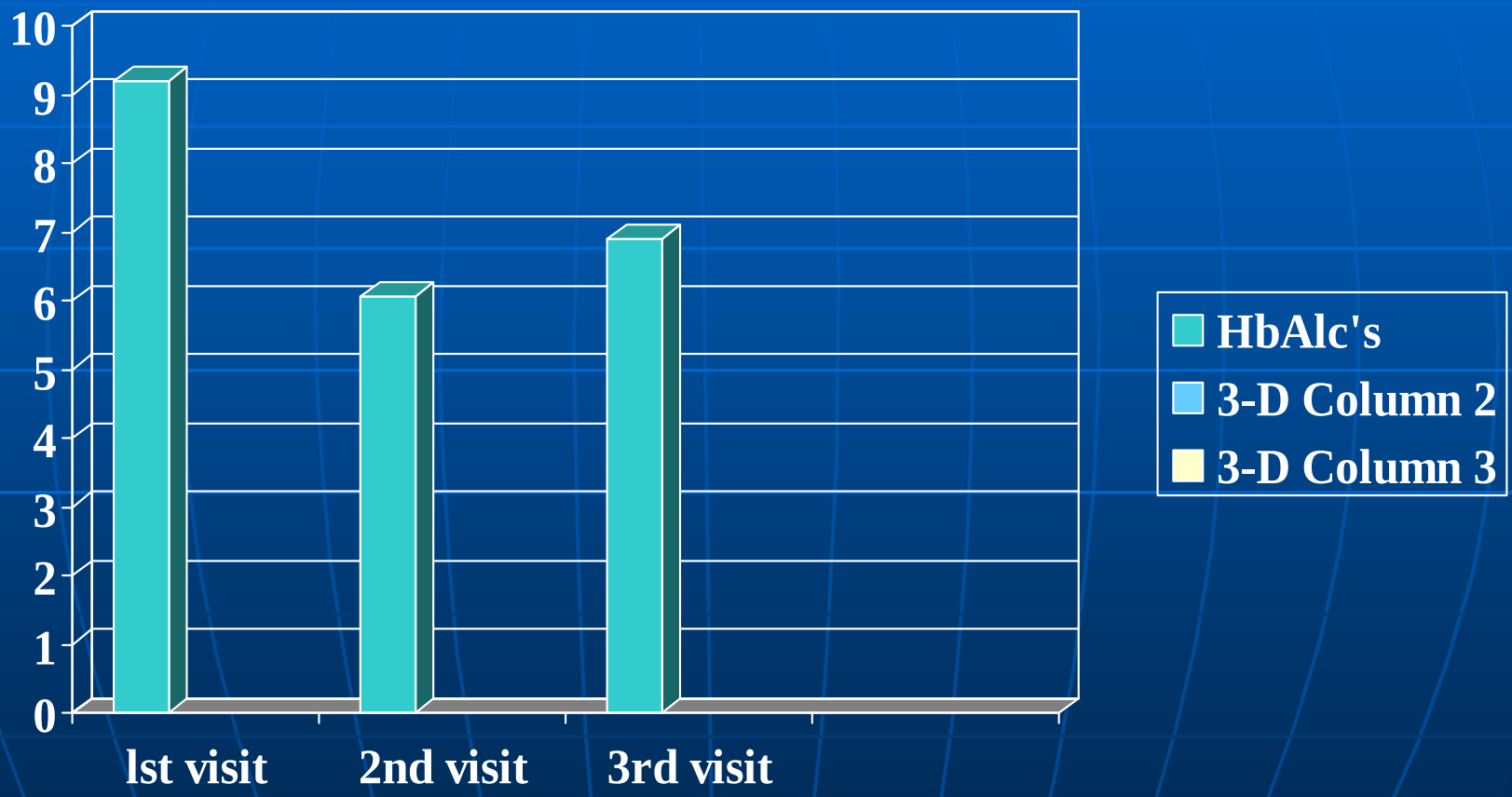
Group Education & Self Management

- **Critical component of the chronic care model**
- **Patients need to perform activities on a regular daily basis**
- **Goals should be done in a collaborative "empowering" way that includes patient choices and values**
- **Self-management goals are integrated at the first visit by each provider**
- **Follow-up on these goals are done at the next visit, or any time the patient sees a provider**
- **Each time a patient is seen by a provider and self-management goals are initiated, the chart is given to data entry for input in the registry**

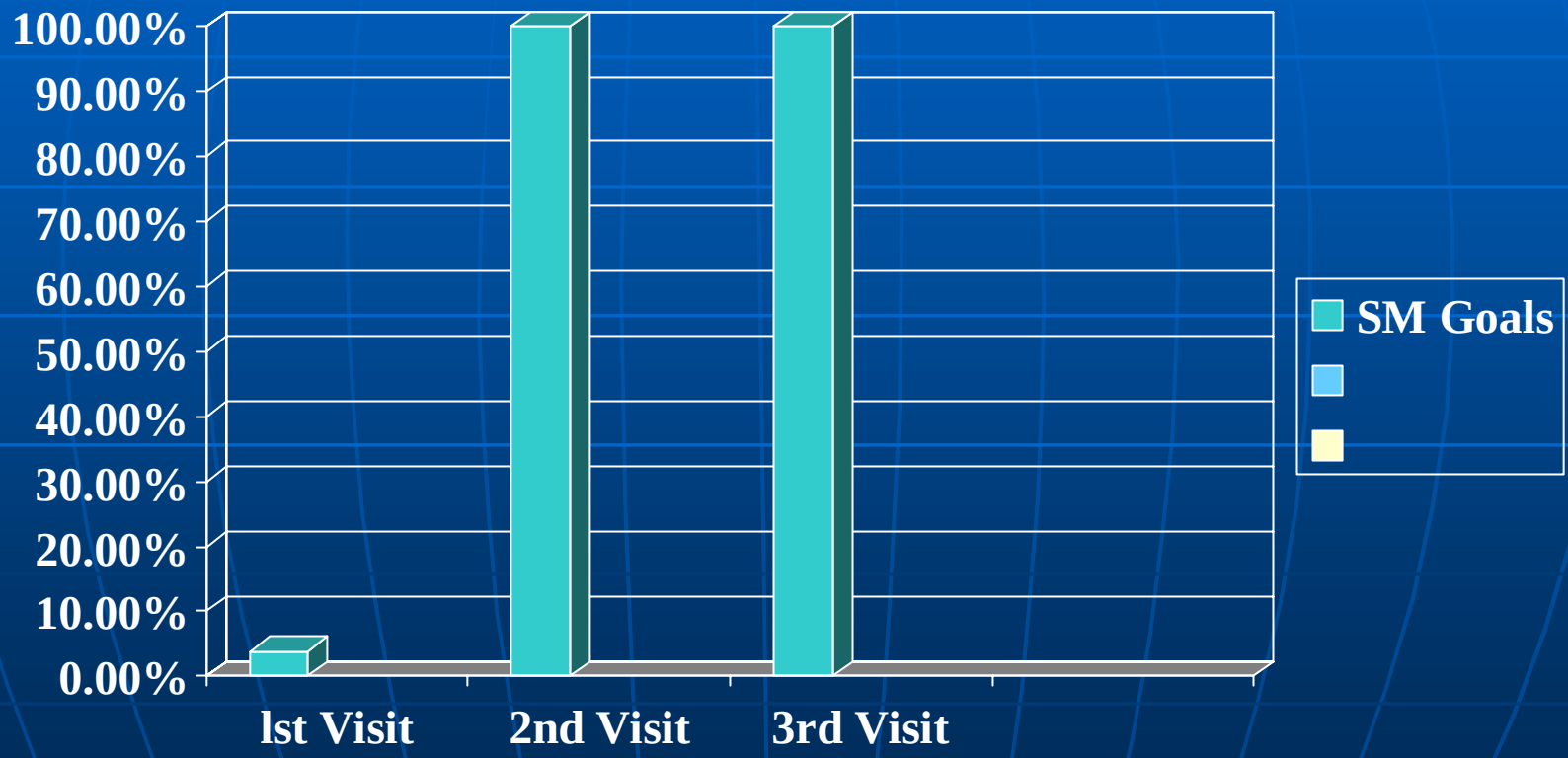
Attendance & Adherence Strategies

- NO SHOW RATE - 47%
- PATIENT INCENTIVES
- SUPPORT GROUPS
- BEHAVIORAL HEALTH

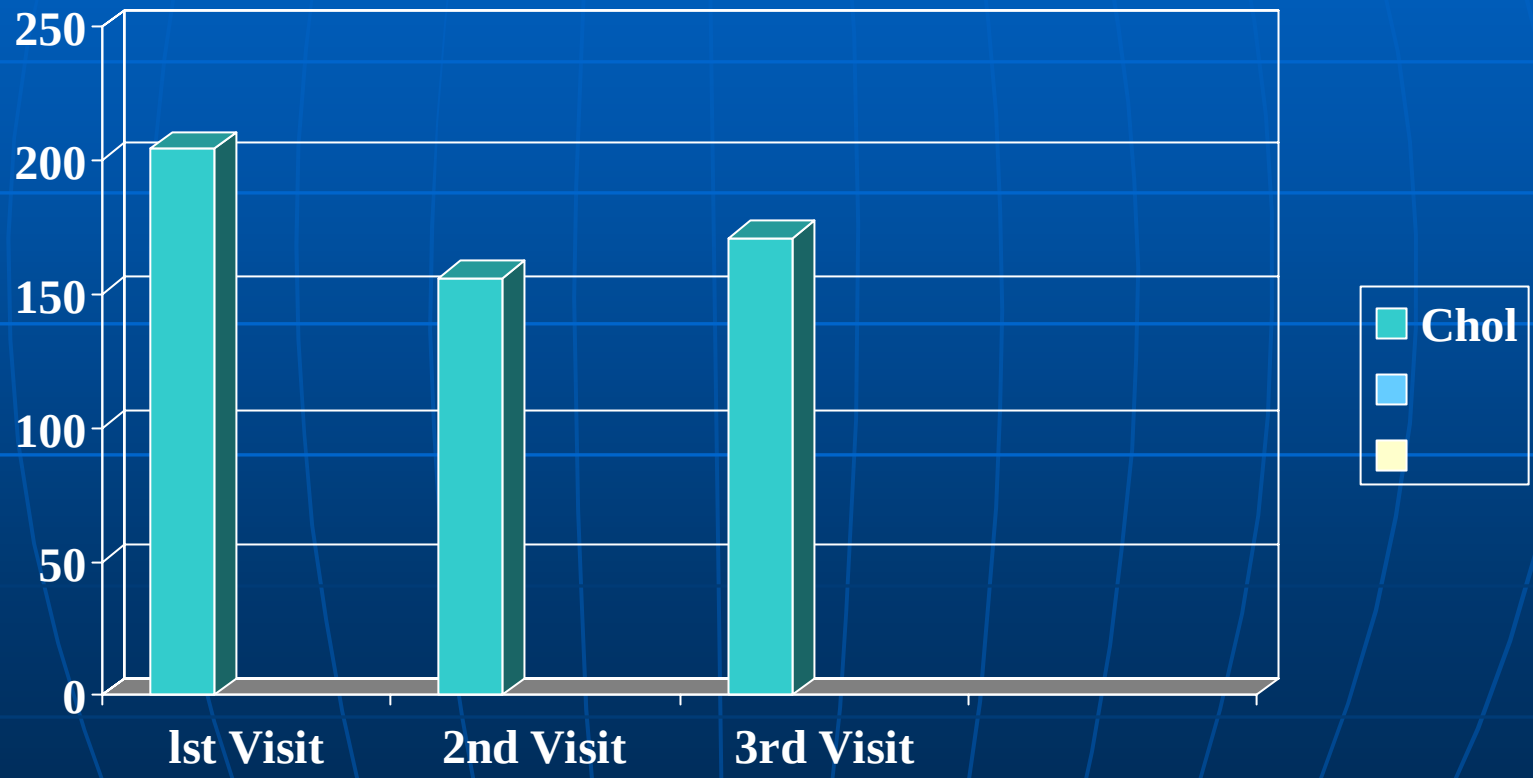
HbA1c's OUTCOMES



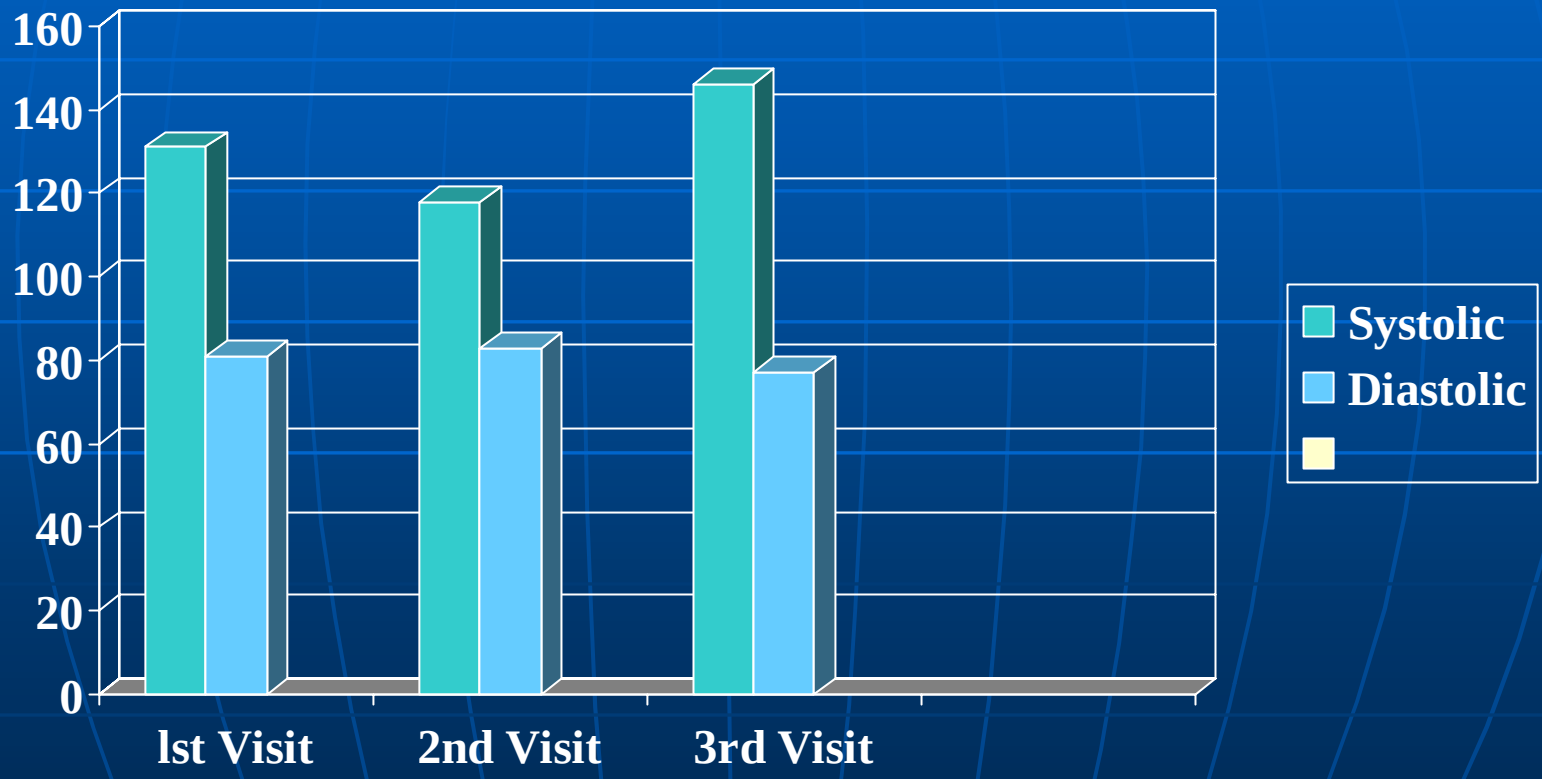
SELF MANAGEMENT OUTCOMES



CHOLESTEROL OUTCOMES



BLOOD PRESSURE OUTCOMES



Participating Community Health Centers

- Clinica Adelante, Inc.
- Mountain Park Health Center
- St. Elizabeth of Hungary Clinic
- Mariposa CHC
- Morenci Health Center
- North Country
- Chiricahua CHC
- Canyonlands CHC
- Marana CHC
- Mariposa CHC
- Pinal County
- Scottsdale Healthcare

Handbook on Diabetes Management

DiabetesHandbookFlyerFinal.pdf